Sexual Violence

Determining the scope of sexual violence in Virginia is a difficult task due to the private and stigmatizing nature of the crime, and lack of a single data source that can provide a definitive representation of its scope (VDH, 2005). Sexual assault is one of the most under reported crimes, with more than half unreported (RAINN, 2007). A study conducted by the Virginia Department of Health indicated that one in four women and one in eight men, in Virginia, have been victims of sexual assault. Furthermore, males perpetrated most of the assaults, and according to a 2003 U.S. Department of Justice survey 70% of victims are assaulted by someone they know (VDH, 2005).

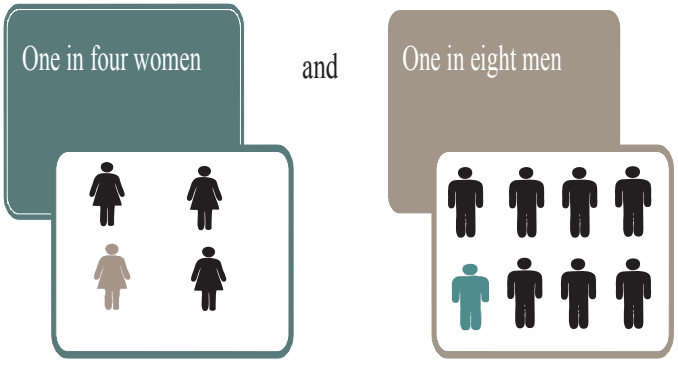
The term sexual assault is often used interchangeably with sexual violence. For the purpose of tracking the prevalence of HIV, sexual assault is defined as direct transmission through sexual violence, which means forced or coercive vaginal, anal or oral intercourse by an HIV-infected person. The type of sexual exposure determines the biological risk of HIV transmission. Receptive anal intercourse has the highest estimated risk of HIV exposure (50 per 10,000), followed by cases involving receptive penile-vaginal intercourse (10 per 10,000), and then receptive oral intercourse (1 per 10,000) (MPAETC,2006). A higher threat of HIV transmission is associated with sexual assault because of the degree of trauma, such as anal/vaginal lacerations and abrasions that occur when force is used. Despite these known threats, evidence of HIV transmission due to sexual assault is difficult to establish due to gaps in collected data (Jenny, 1990). In Virginia, the risk of contracting HIV infection because of rape is unknown. Despite the known data limitations, the relationship between HIV transmission and sexual assault is important to HIV prevention planning. Virginia law requires HIV testing of those arrested or indicted for a sexual assault offense and allows disclosure of the HIV test results to the victim (Code of Virginia, 2007).

The use of post-exposure prophylaxis for nonoccupational exposure to HIV (nPEP) for sexual assault survivors has been widely encouraged both in the United States and internationally. Post-exposure

According to the Virginia Uniform Crime Report, 4,973 forcible sex offenses (5,295 victims) were reported to law enforcement agencies during 2005 (VDH, 2005).

Females were victims in 86% of the 5,295 offenses. Sixty percent of the female victims were under age 18, and 86% of males were under age 18 (VDH, 2005).

According to a randomized survey of all Virginia citizens, 49.4% of the 489 females who experienced sexual assault were assaulted multiple times (VDH,2005).



has been a victim of sexual assault in her or his lifetime

Source: VDH, 2005

prophylaxis (PEP) prevents or aborts transmission of HIV with rapid initiation of short-term antiretroviral therapy (ART) following exposure. Studies of PEP have demonstrated the greatest reduction in HIV transmission when antiretroviral medications are administered immediately after exposure to HIV-infected blood and body fluids. The efficacy of PEP is diminished after 36 hours and is minimal after 72 hours (CDC,2005). The most direct evidence supporting the efficacy of PEP is related to occupational injuries of health care workers. In 2001, prompt initiation of PEP was associated with an 81% decrease in the risk of acquiring HIV (Cardo,1997).

The CDC recommends that victims of sexual assault should be tested and administered prophylaxis for sexual transmitted infections (CDC, 2006). Although this recommendation is widely accepted, timing, cost and adherence are all barriers to the administration of nPEP. Difficulty in obtaining nPEP has been reported in Virginia. Physicians, who do not provide HIV care, are often unfamiliar with and reluctant to prescribe antiretroviral treatment. Assault victims without insurance have no resources to pay for a course of nPEP and ADAP funds cannot be used to pay for medications for those without documented HIV infection. No other public payment sources exists and this gap in care should be addressed. The psychosocial needs of a person who was sexually assaulted may limit the ability of an individual to begin the nPEP regimen within 72 hours. A 28 day regimen of nPEP costs approximately $1,300 and exposed persons are frequently unable to complete nPEP due to side effects (Vázquez, 2005).

Additional studies are needed to better delineate the rates of HIV seroprevalence among sexual violence perpetrators and the efficacy of nPEP after sexual exposure. This research will help bridge the gap between HIV prevention planning and sexual assault prevention strategies.

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